Canberra Fetal Assessment Centre
Gynaecological Imaging

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Ultrasound Request Form

Patient Name: _____ DOB: ___/___/_____

Contact Phone: _____

Clinical Details: LMP _____ EDC _____ G _____ P _____

Clinical History/Indications:

_____

_____

_____

OBSTETRIC ULTRASOUND EXAMINATION

- ☐ Early Pregnancy Assessment
- ☐ Nuchal Translucency with Biochemistry
  - o Request form provided by you ☐ (PAPP-A, BHCG, PGF)
- ☐ CVS or Amniocentesis (Blood group:_____)
- ☐ Morphology examination (after 18 weeks)
- ☐ Growth and wellbeing
- ☐ Tertiary and Second opinion examination
- ☐ Multiple pregnancy:
  - o Morphology o Growth & wellbeing
- ☐ Non invasive prenatal testing counselling:
- ☐ Other

GYNAECOLOGICAL ULTRASOUND EXAMINATION

- ☐ Pelvic Ultrasound
  - ☐ Endometriosis Scan
  - ☐ Abnormal Uterine bleeding
- ☐ Saline Sonography
- ☐ HyCoSy Contrast Ultrasound with tubal patency assessment

Referring Doctor: _____ Provider Number: #_____

Date of Referral ___/___/_____ Signature: _____

Referrer Address: _____

Additional reports to: _____